



Compulsory Driver's Medical Examination

(All details must be supplied with signatures and all questions answered)

Name

Male ☐ Female ☐

1. Present Weight kgs 2. Height cms 3. Age
4. Have you any defect in sight? *(attach details)* Yes ☐ No ☐
5. Are you presently receiving medical treatment? *(attach details)* Yes ☐ No ☐
6. Are you, or have you been in receipt of a sickness benefit or Worker's Compensation Payment? *(attach details)* Yes ☐ No ☐
7. Have you any physical defects? *(describe)* Yes ☐ No ☐

11. Epilepsy or fits? Yes ☐ No ☐
12. Weak heart or heart disease? Yes ☐ No ☐
13. Shortness of breath or dizziness? Yes ☐ No ☐
14. Swelling of ankles? Yes ☐ No ☐
15. Chronic Cough or Sputum? Yes ☐ No ☐
16. Tuberculosis? Yes ☐ No ☐
17. Digestion or stomach disorders? Yes ☐ No ☐
18. Frequent diarrhoea or dysentery? Yes ☐ No ☐
19. Deafness or discharging ear? Yes ☐ No ☐
20. Asthma or severe Hayfever? Yes ☐ No ☐
21. Diabetes? Yes ☐ No ☐
22. Frequent Headache or migraine? Yes ☐ No ☐
23. Mental illness or Nervous Breakdown? Yes ☐ No ☐
24. Any other illness or medical condition? *(Attach details)* Yes ☐ No ☐
25. Have you had any previous medical condition? *(Attach details)* Yes ☐ No ☐

Have you ever suffered from any of the following:

8. High Blood pressure? Yes ☐ No ☐
9. Blood in urine or faeces? Yes ☐ No ☐
10. Rheumatic Fever, Rheumatism, Joint Pain or frequent headache? Yes ☐ No ☐

Declaration

I declare that all answers are true and correct. I agree to advise HRV of any change that may occur in my medical condition.

Signature

Date

Please Sign

Please Date

Medical Practitioners Report (Medical Practitioners Use Only)

General Appearance

Is there any hernia?

Nervous System

Ear, Nose & Throat

Gland Areas

Lungs

Abdomen

Condition of spine, limbs, joints

BLOOD PRESSURE Systolic mmHg

Diastolic mmHg

CONDITION OF HEART Size Sounds Rhythm Pulse Rate

EYES Uncorrected R6/ Uncorrected L6/ Corrected R6/ Corrected L6/

HEARING Right Left **URINE** Glucose Albumin

Detail any relevant aspects of history:

Examiners Statement NB: Please ensure you tick the appropriate fitness category

The applicant is: fit to drive: ☐ unfit to drive: ☐ requires referral to HRV Medical Panel to determine driving fitness: ☐

Name and address of examining doctor

Signature

Date